Supreme Court, U.S.
FILED
98 215 JUL 20 1998
OFFICE OF THE CLERK

(1)

Nº. _____

In The
Supreme Court of The United States
October Term 1997

ANDREA HELLER,
Petitioner,

v.

FORTIS BENEFITS INSURANCE COMPANY,
Respondent.

Petition For A Writ Of Certiorari
To The United States Court of Appeals
For The District of Columbia Circuit

PETITION FOR WRIT OF CERTIORARI

JOSEPH F. CUNNINGHAM
Cunningham & Associates
110 North Royal Street, Suite 401
Alexandria, Virginia 22314
(703) 684-0069

Attorney for Petitioner
**Counsel of Record*

APPELLATE ADVANTAGE
4264 N. OAK TRAFFICWAY◆KANSAS CITY, MO 64116◆816-453-2424

61 pp

QUESTIONS PRESENTED

Whether the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §1133 (1994), which provides that "every employee benefit plan shall-- (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim," permits an employee benefit plan to deny benefits with minimal notice and no appellate review of a participant's claim, as found acceptable by the Court of Appeals for the District of Columbia Circuit.

Whether a failure of an ERISA benefit plan to provide adequate notice of the bases for denial of an employee benefit claim and its failure to provide any appellate review of the decision to deny the participant's claim, as sanctioned by the Court of Appeals, encourages litigation and unnecessary resort to the federal courts relating to benefit plan decisions better left to an administrative process, as contemplated by 29 U.S.C. §1133?

Whether the Court of Appeals, contrary to rulings by other federal Courts of Appeals, was correct in approving

restitution of benefits paid by an insurance company benefit plan administrator to a participant admittedly disabled when neither the plan documents nor any correspondence from the insurance company to the participant indicated that restitution was permissible nor anticipated?

TABLE OF CONTENTS

Page

Question Presented i

Table of Contents iii

Table of Citations v

Opinion Below viii

Statement of Jurisdiction viii

Statutory Provision Involved viii

Statement of the Case 1

A. The Employee Retirement Income Security Act of 1974 1

B. The Proceedings Below 7

Reasons for Granting the Writ 11

I. The Petition Should be Granted Because the Court of Appeals' Interpretation of 28 U.S.C. §1132 Conflicts with Interpretations of the Third, Sixth, and Eleventh Circuits and Aggravates the Existing Split of Authority in the Circuit Courts 12

II. The Petition Should Be Granted Because the Decision of the Court of Appeals is Erroneous in rejecting the entitlement of a participant in a benefit plan to fair notice of a claim denial and the right to an adequate administrative appeal 15

III. The Petition Should Be Granted Because the Question Presented Is Important, and its present resolution below encourages unnecessary litigation 19

CONCLUSION 23

APPENDICES

TABLE OF CITATIONS

Page

Cases Cited:

Award Service, Inc., v. Northern California Retail Clerks Union and Food Employers Joint Pension Trust Fund, 763 F.2d 1066 (9th Cir. 1985) 12, 13

Brehmer v. Inland Steel Industrial Pension Plan, 114 F.3d 656, 662 (7th Cir. 1997) 8

Brown v. Blue Cross & Blue Shield of Alabama, 898 F.2d 1156 (11th Cir. 1990) 22

Cort v. Ash, 422 U.S. 66 (1975) 13

Crown Cork & Seal Co. v. Teamsters Pension Fund, 549 F. Supp. 307 (E.D. Pa. 1982), *aff'd mem.*, 720 F.2d 661(3d Cir. 1983) 14

Dime Coal Co. v. Combs, 796 F.2d 394 (11th Cir. 1986) 14

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989) 7

Halpin v. W.W. Grainger, Inc.,
962 F.2d 685 (7th Cir. 1992) 16, 17, 18, 21

Kent v. United of Omaha Life Insurance Co.,
96 F.3d 803 (6th Cir. 1996) 8

Massachusetts Mutual Life Ins. Co. v. Russell,
473 U.S. 134 (1985) 2

McLean Hospital Corp. v. Lasher,
819 F. Supp. 110 (D. Mass. 1993) .. 17, 18, 19, 20

Plucinski v. I.A.M. National Pension Fund,
875 F.2d 1052 (3d Cir. 1989) 13

Richardson v. Central States, Southeast & Southwest Areas Pension Fund,
645 F.2d 660 (8th Cir. 1981) 21

Short v. Central States, Southeast & Southwest Areas Pension Fund,
729 F.2d 567 (11th Cir. 1984) 21

Taft v. Equitable Life Assurance Society,
9 F.3d 1469 (9th Cir. 1993) 22

Whitworth Brothers Storage Co. v. Central States,
794 F.2d 221 (6th Cir. 1986) 14

Wilson v. Group Hospitalization and Medical Services, Inc., 791 F. Supp. 309 (D.D.C. 1992) 22

Statutes Cited:

28 U.S.C. §1254 (1) viii

29 U.S.C. §1001-1461 (1988) ..... *passim*

Rule Cited:

Pension and Welfare Benefits Administration, Labor, 29 C.F.R. §2560-503-1 (1993) 4, 5, 17

Other Authority Cited:

120 Cong. Rec. 29,932 (1974), *reprinted in* U.S.C.C.A.N. 5177 2

Sue Your HMO? Bad Idea, Wall St. J., June 12, 1998 23

Petitioner, Andrea Heller, respectfully requests that a writ of certiorari be issued to review the judgment of the United States Court of Appeals for the District of Columbia Circuit in this case.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the District of Columbia Circuit is denominated *Andrea Heller v. Fortis Benefits Insurance Co.* (App. A).

STATEMENT OF JURISDICTION

The judgment of the United States Court of Appeals for the District of Columbia Circuit (Court of Appeals) was entered on May 1, 1998. The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

STATUTORY PROVISION INVOLVED

Section 1133 of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §1133, states, in relevant part, that "every employee benefit plan shall-- (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in such a manner calculated to be understood by the participant, and (2) afford a reasonable opportunity to any

participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim."

STATEMENT OF THE CASE

Petitioner Andrea Heller (Heller) sued Fortis Benefits Insurance Company (Fortis) in February of 1992 in the District Court of the District of Columbia. She alleged that Fortis, as an ERISA benefits plan administrator, breached its fiduciary duty in violation of ERISA by improperly denying her disability benefits and failing to provide adequate review of its denial. Fortis claimed that the denial and review were proper and sought restitution for certain benefits paid. The district court agreed that the benefits termination and appeals procedure employed by Fortis were adequate and granted Fortis restitution of some of those benefits paid. The Court of Appeals affirmed.

A. The Employee Retirement Income Security Act of 1974

This case involves the construction of a provision in ERISA. An understanding of the statutory language is aided by an examination of the historical background of ERISA.

It is horn book law that at common law, a trustee owes a duty of loyalty to a beneficiary, which obligates the trustee to act in good faith and in the sole interest of the beneficiary. Recognizing the significance of the fiduciary relationship and the level of confidence necessary for such arrangement, courts require a strict adherence to this duty. However, it was

believed by Congress that state and federal laws were generally ineffective in protecting the interests of pension and health benefit plan participants and beneficiaries prior to the enactment of ERISA. In 1974, with an excess of $300 billion in assets in such plans, there was concern about the misuse of plan assets by pension or welfare plan administrators, through self-dealing, imprudent investing, and misappropriation. Thus, Congress enacted ERISA, which sought to prevent such abuses by imposing strict fiduciary obligations on persons exercising discretion and responsibility over the management, handling, or disposition of plan assets.[1]

ERISA protects the rights of plan participants and beneficiaries by codifying common law principles with respect to trusts. Consequently, Section 1 imposes on fiduciaries various obligations: reporting and disclosure standards, minimum participation and vesting standards, funding

---

[1] 120 Cong. Rec. 29,932 (1974) (statement of Sen. Williams, Chairman, Senate Committee on Labor and Public Welfare) ("[T]he legislation imposes strict fiduciary obligations on those who have discretion or responsibility respecting the management, handling, or disposition of pension or welfare plan assets. The objectives of these provisions are to make applicable the law of trusts; . . . to establish uniform fiduciary standards to prevent transactions which dissipate or endanger plan assets; and to provide effective remedies for breaches of trust."), *reprinted in* 1974 U.S.C.C.A.N. 5177, 5186. *See also Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 140 n.8 (1985).

standards, and strict fiduciary standards.[2] Under Section 3(21)(A), a fiduciary is a person who renders investment advice for compensation, or a person who exercises discretionary authority or control over the management of a benefit plan, a plan's administration, or the disposition of a plan's assets.[3] Consequently, Section 404(a) imposes a common law duty of loyalty on fiduciaries, mandating performance solely in the interest of participants or beneficiaries. Furthermore, regarding benefit denials, ERISA states that every employee benefit plan shall:

(a) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the

---

[2]29 U.S.C. §1021-1031; 1051-1061; 1081-1086; 1131-1145 (1988).

[3]Section 3(21)(A) of ERISA states:

Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting the management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

29 U.S.C. §1002(21)(A) (1988).

plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.[4]

In 1977, to formalize the procedures concerning ERISA claims, the U.S. Department of Labor promulgated a regulation requiring ERISA-governed benefit plans to establish and maintain "reasonable" claims procedures.[5]

---

[4]29 U.S.C. §1133.

[5]Section 2560.503-1 states:
(1) A claims procedure will be deemed to be reasonable if it:

> (i) Complies with the provisions of paragraphs (d) through (h) of this section, except to the extent that it is deemed to comply with some or all of such provisions under the authority of paragraph (b)(2) or paragraph (j) of this section.
>
> (ii) Is described in the summary plan description, as required by §2520.102-3,
>
> (iii) Does not contain any provision, and is not administered in a way, which unduly inhibits or hampers the initiation or processing of plan claims, and

Significantly, the regulation provides that a denial or termination of benefits must be communicated to the beneficiary or participant through a notice detailing the decision. The rule states, "[i]f a claim is wholly or partially denied, notice of the decision, meeting the requirements of paragraph (f) of this section, shall be furnished to the claimant within a reasonable period of time after receipt of the claim by the plan."[6] Furthermore, the notice must contain certain information in support of the decision:

(1) [t]he specific reason or reasons for the denial;

(2) [s]pecific reference to pertinent plan provisions on which the denial is based;

(3) [a] description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

(4) [a]ppropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review."[7]

> (iv) Provides for informing participants in writing, in a timely fashion, of the time limits set forth in paragraphs (e)(3) and (g)(3) and paragraph (h) of this section.

29 C.F.R. §2560.503-1(b).

[6]29 C.F.R. §2960.503-1(e).

[7]29 C.F.R. §2960.503-1(f).

Thus, a participant whose claim has been denied is entitled to an explanation of the reasons behind the decision; the bases in the plan for such action; suggestion of additional information needed from the claimant; and how to accomplish an appellate review in-house.

If there were any doubt as to what must be done, the Department of Labor regulation states:

(1) [e]very plan shall establish and maintain a procedure by which a claimant or his duly authorized representative has a reasonable opportunity to appeal a denied claim to an appropriate named fiduciary or to a person designated by such fiduciary, and under which a full and fair review of the claim and its denial shall include but not be limited to provisions that a claimant or his duly authorized representative may:

(i) [r]equest a review upon written application to the plan;

(ii) [r]eview pertinent documents; and

(iii) [s]ubmit issues and comments in writing.

The questions presented here relate to whether, under the statutory language employed by Congress, the regulations adopted to enforce such provisions, and the existing case law, an insurance company administering a benefit plan under ERISA may terminate benefits to a participant by giving

inadequate notice of the bases for the decision, contrary to law and regulations; no right to appeal or review, also contrary to law and regulations; and then obtain restitution for some benefits already paid without either plan authority nor notice to the participant.

B. Proceedings Below

Heller filed suit under 29 U.S.C. §1132(a)(1)(B), alleging violation of ERISA. Fortis counterclaimed for restitution of benefits it paid Heller after January 1991, the point in time at which it deemed Heller ineligible. On cross-motions for summary judgment, the district court ruled in Fortis' favor on both Heller's claim and Fortis' counterclaim.

Since the insurance company claims department was not vested with any discretion in administering the Fortis disability insurance policy issued to Heller in 1985, the court of appeals reviewed the grant of Fortis' motion for summary judgment, as well as the denial of Heller's own motion for summary judgment, under the *de novo* standard, as required by *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989). It reviewed the statutory language of ERISA, particularly Section 503, which provides that a benefits plan provider must give "adequate notice" of denial of benefits, as well as a " reasonable opportunity" for

"full and fair review"; all of which had not been done.[8] It acknowledged that the fiduciary must usually review a denial of claim within 120 days. Fortis had not done so. Examining the facts of the case, it found that "Fortis never advised Heller of her right to appeal in its denial letter," and that "the initial letter from Fortis informing Heller of the denial of her disability benefits did not conform to the requirements of the regulations." p. 8. Despite such direct violation of Section 503, however, the circuit court held that the letter constituted "adequate notice" of the denial. Relying on *Kent v. United of Omaha Life Insurance Co.*, 96 F.3d 803, 807 (6th Cir. 1996), which stated that "when claim communications as a whole are sufficient to fulfill the purposes of Section 1133 the claim will be upheld even if a particular communication does not meet those requirements," it found the letter to be acceptable as notice of denial simply because Fortis had mentioned Heller's right to appeal in a subsequent letter. *Kent*, however, involved a plan administrator vested with discretion, whereas the Fortis claims manager/ administrator had none. The court also cited *Brehmer v. Inland Steel Industrial Pension Plan*, 114 F.3d 656, 662 (7th Cir. 1997), a case involving a pension dispute, not a health plan, and one again where the administrator possessed discretionary authority over claims, which Fortis lacked. The court also concluded that by filing suit, Heller had waived any right to a meaningful review process, ignoring the reality that no such review process even existed, and she

---

[8] 29 U.S.C. §1133.

was aware of this violation of the statute and regulations by Fortis, giving her no other option but litigation.

The circuit court only briefly discussed the issue of whether the appeals procedure provided by Fortis was adequate under the requirements of ERISA and did not determine whether Fortis violated ERISA, despite this being a basic issue raised on appeal. It stated that Heller failed to make use of Fortis' appeals process and thus failed to exhaust administrative remedies, even though Heller clearly followed the proper procedures, including submitting a number of documents to Fortis as evidence of eligibility, before learning that no review procedure actually existed. Despite such attempts on the part of Heller to administratively appeal the decision of the insurance company's claims department to terminate her disability payments, the court found that "she cannot establish that she was denied 'a fair opportunity for review' of her claim because she never gave Fortis a chance to complete its review." This "Catch 22" reasoning was based upon the fact that Heller filed suit shortly after submitting additional information to the insurance company for review. It ignored Fortis' expressed position to Heller that there were no circumstances that would prompt it to reverse its position on appeal and the admitted fact that the appeal process essentially was non-existent. Consequently, the court totally evaded the significant questions of whether Fortis complied with ERISA requirements by refusing review of new information provided by Heller, providing Heller no appeal

review for denial of her benefits, and whether this non-compliance required restitution of benefits to her by Fortis until the law and regulations were complied with by the insurance company.

The court then addressed the question of whether Fortis was entitled to a restitution of certain payments made to Heller for which Fortis later decided that she was ineligible. It cited the particular language of ERISA, which specifies that a civil action may be brought by a fiduciary "to enjoin" any act violative of ERISA or the plan, or "to obtain equitable relief" to redress such violation. Moreover, it acknowledged that "ERISA itself does not explicitly provide a statutory right of restitution." However, it found that "Congress intended federal courts to fashion a federal common-law under ERISA, and this [sic] permits application of a federal common-law doctrine of unjust enrichment" for the purpose of safeguarding the corpus of the benefits plan. It confused the Fortis insurance company health benefits plan with a pension plan and somehow reasoned it was better to protect the insurance company than a plan beneficiary never put on notice of an intent by the carrier to seek restitution. Therefore, it found that Fortis could properly seek restitution of payments made to Heller after the point at which she was deemed ineligible by the insurer without any independent review. It viewed the non-waiver letter from the insurance company as actually providing a notice of intent to seek restitution and sanctioned this *sub silentio*, feeble basis for entitlement.

The court acknowledged that "*[h]er plan did not* specifically provide for restitution and Fortis never expressly stated that its payment of the benefits after the five year term expired was conditional." Despite the conspicuous absence of such language, the court stated that the insurer's statement that payment of benefits is not an admission of liability translated into notice to Heller that it expected reimbursement for benefits for which she was not eligible. Even though the plan did not provide for restitution or even reimbursement for payments made "mistakenly," such windfall to the carrier was sanctioned because the plan did not specifically prohibit it. Thus, the court found that the district court did not abuse its discretion in ordering the unemployed and disabled Heller to pay restitution for these payments to Fortis. Such holding is unique in American law and remarkable in its viciousness to a health plan participant.

REASONS FOR GRANTING THE WRIT

This case presents a timely and rare opportunity for this Court to address issues of foremost impression here. First, the decision of the District of Columbia Circuit is in direct conflict with decisions rendered by the Third, Sixth, and Eleventh Circuits regarding the issue of restitution from health plan participants. With this conflict, it aggravates a split in the circuit courts that this Court must address. Furthermore, the court below erred in holding that the defective notice and non-existent review afforded by the insurance company to a plan

participant was adequate under ERISA and its interpretive regulations. On the contrary, the language of the statute and the regulations clearly mandates certain formal requirements regarding notice and the right to appeal denial of benefits, which Fortis admittedly failed to satisfy. Finally, the case concerns important policy issues regarding numerous workers that rely on ERISA-related plans for their health benefits. It encourages resort to litigation when Congress directed otherwise. It is stupid policy at best. Therefore, given the split in authority, the error of the court below, and the significance of the issues discussed, this Court should grant the petition.

I. THE PETITION SHOULD BE GRANTED BECAUSE THE COURT OF APPEALS' INTERPRETATION OF 28 U.S.C. §1132 CONFLICTS WITH INTERPRETATIONS OF THE THIRD, SIXTH, AND ELEVENTH CIRCUITS AND AGGRAVATES THE EXISTING SPLIT OF AUTHORITY IN THE CIRCUIT COURTS.

The Circuit Courts have been split on the issue of whether restitution is a permissible remedy under ERISA. In *Award Service, Inc., v. Northern California Retail Clerks Unions and Food Employers Joint Pension Trust Fund*, 763 F.2d 1066 (9th Cir. 1985), an employer brought action against a multi-employer pension fund to recover mistakenly paid contributions. The court recognized that section 403 does not

expressly provide for such remedy. It then applied the four-factor test of *Cort v. Ash*, 422 U.S. 66 (1975): (a) employers were within a protected class under the 1980 amendments to Section 403(c)(2)(A), (2) section 403(c)(2)(A)(ii) evidences a congressional intent to create a private remedy in favor of the employer, (3) implying such private remedy furthers the congressional scheme of permitting restitution, and (4) a federal cause of action is wholly appropriate given federal-state comity. *Award Service*, 763 F.2d at 1068. Therefore, the court held, "a right of action is properly implied by section 403" and the employer is entitled to restitution for pension funds paid by mistake. *Id.*

Other courts, however, differ on this issue. In *Plucinski v. I.A.M. National Pension Fund*, 875 F.2d 1052 (3d Cir. 1989), a pension plan provider sought reimbursement from an employer for contributions paid by mistake on behalf of an employee. The court found, first, that "ERISA does not provide a right of action for employers to recover mistakenly paid contributions to multiemployer pension funds." *Id.*, at 1054. As for an implied right of action for restitution, the court applied the same *Cort v. Ash* test as did the Ninth Circuit in *Award Service*. *Id.*; *Cort*, 422 U.S. at 66; *Award Service*, 763 F.2d at 1068. However, it held that "[b]ecause we find that the heart of the implied right of action inquiry--legislative intent--has not been established, we hold that there is no implied right of action under ERISA which would enable employers to compel restitution of mistakenly paid pension

fund contributions." *Id.*, at 1056. The Sixth And Eleventh Circuits have also held that there is no implied cause of action for pension benefit restitution under ERISA. *See Whitworth Brothers Storage Co. v. Central States*, 794 F.2d 221 (6th Cir. 1986); *Dime Coal Co. v. Combs*, 796 F.2d 394 (11th Cir. 1986); *see also Crown Cork & Seal Co. v. Teamsters Pension Fund*, 549 F. Supp. 307 (E.D. Pa. 1982), *aff'd mem.*, 720 F.2d 661 (3d Cir. 1983). The Eleventh Circuit held in *Dime Coal* that "neither the statute nor the legislative history reveals a congressional intent to create a private right of action," and that the comprehensive nature of the remedies provided by ERISA indicates that the remedy of restitution was deliberately omitted. 796 F.2d at 399, 399 n. 7. Given such differences in the reading of remedies available under ERISA, this Court should grant this petition to review these conflicts. Moreover, the present case does not reference pension monies at all; simply insurance company disability benefits, payment of which would in no way adversely impact on other covered employees as might be the case with pension monies, but return of which severely affects this unemployed, disabled plan participant.

In the case below, the court acknowledged that neither the plan itself nor other documentation, including correspondence from Fortis, mentioned restitution, when it stated, "[Heller's] plan did not specifically provide for restitution and Fortis never expressly stated that its payment of the benefits after the five year term expired was

conditional." However, it construed Fortis statement disclaiming liability as demonstrating an intent to seek reimbursement for benefits for which Heller was found not eligible. This reasoning is breathtaking in its insufficiency. Ignoring specific rulings by other circuit courts, the court below held that the insurance company was entitled to restitution, a remedy specifically omitted by ERISA and disfavored by the majority of circuits.

II. THE PETITION SHOULD BE GRANTED BECAUSE THE DECISION OF THE COURT OF APPEALS IS ERRONEOUS IN REJECTING THE ENTITLEMENT OF A PARTICIPANT IN A BENEFIT PLAN TO FAIR NOTICE OF CLAIM DENIAL AND THE RIGHT TO AN ADEQUATE ADMINISTRATIVE APPEAL.

The Court of Appeals is mistaken in its interpretation of ERISA. With its rules of vesting, disclosure, reporting, and fiduciary requirements, ERISA seeks to protect the rights of plan participants from the misuse and abuse by fiduciaries. In delineating the claims processes for private benefit plans, it requires plan administrators to adhere to certain procedures regarding claim adjudication and appeal. While also providing a vehicle for litigation, however, ERISA explicitly limits the form of relief to the avenues provided by and specified in the statutory language. The limitation on ERISA equitable remedies regarding plan benefit denials is well known, but it

was intended that in-house review procedures would make up for limited legal redress in the courts. The statutory and regulatory language applicable to this dispute so suggests, but the circuit court decision sends the opposite message -- that the absence of adequate notice of a reason for benefit denial and no review whatsoever, is perfectly acceptable.

Even though this Court has never dealt with the notice and appeal procedures under ERISA, lower courts have visited this issue on numerous occasions. These courts generally recognize that ERISA imposes certain duties on a fiduciary resulting from a negative claim adjudication. The court in *Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685, 688 (7th Cir. 1992), stated that "ERISA requires that specific reasons for denial be communicated to the claimant and that the claimant be afforded an opportunity for 'full and fair review' by the administrator." In determining whether a certain pension plan's procedures complied with the requirements of ERISA, it is incumbent to look to the statute itself, the factual situation, and the degree to which the procedures employed approximated that process specified by the regulations. The *Halpin* court wrote, "[t]he purpose of the statute and regulations must be our guide: was the beneficiary supplied with a statement of reasons that, under the circumstances of the case, permitted a sufficiently clear understanding of the administrator's position to permit effective review." *Id.*, at 690. Thus, the communication must be precise in detailing the reasons for denial of benefits and the

appropriate process of appeal. In *Halpin*, the court found that "the notice of decision must include specific reasons." *Id.*, at 693. Furthermore, it held that the termination letter was inadequate under ERISA guideline as it "failed to meet the regulatory requirements, because it did not give 'a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary'." *Id.*, at 691 (quoting C.F.R. §2560-503-1(f)). Compare this effort at fairness with the admittedly inadequate mechanism employed by the insurance company here; particularly when Heller had such additional material available to provide in the form of medical testimony.

A termination letter fails to satisfy the requirements under ERISA if it omits certain key elements. The letter must, above all, contain a detailed analysis of the reasons behind the adjudication. Furthermore, it must notify the beneficiary of the appeal procedure. In *McLean Hospital Corp. v. Lasher*, 819 F. Supp. 110, 119 (D. Mass. 1993), the court stated, "letters which contain only 'conclusory' reasons for denial fail to indicate information needed to appeal, provide only sparse information as to procedures for review and lack notice of appeal rights are deemed insufficient and do not comply with section 1133." It then found that the benefit termination letter "clearly insufficient" because it failed, as here, to mention any right of review. *Id.*, at 125. Therefore, the court held that the plan provider's letter denying benefits there violated ERISA

regulations, and, in a scholarly opinion, explained the many reasons why a meaningful opportunity for administrative review of benefit denials made good common sense.

The court of appeals in *Heller* dodged this approach when it deemed Fortis' letter of simple denial gave adequate notice because the insurance company had in unspecified ways subsequently communicated with Heller's attorney. It evaded the issue of the absence of any appeal procedure by concluding suit had been filed once Heller's lawyer learned there was none and so the absence of such procedure could not have been prejudicial to her. (p. 8). Moreover, it acknowledged the deficiencies in Fortis' termination letter when it wrote that "'[t]he letter did not advise her of any right to appeal the benefits determination," and that "the initial letter from Fortis informing Heller of the denial of her disability benefits did not conform to the requirements of the regulation." (p. 8) Despite these shortcomings, and contrary to the rulings of *Halpin* and *McLean Hospital, inter alia,* the court concluded that Fortis satisfied procedural requirements under ERISA and upheld summary judgment in favor of the insurance company. In doing so, it approved insurance company short cuts that only benefit the carrier and disregard the statute, regulations, and better-reasoned case law.

III. THE PETITION SHOULD BE GRANTED BECAUSE THE QUESTION PRESENTED IS IMPORTANT AND ITS PRESENT RESOLUTION BELOW ENCOURAGES UNNECESSARY LITIGATION.

This case presents important public policy issues that may only be reviewed and clarified by this Court. Central to the discussion regarding the appeal process of denial of benefits is the exhaustion doctrine. Even though ERISA does not specifically require claimants to exhaust administrative remedies before filing suit, courts have long recognized this doctrine in various cases. The court in *McLean Hospital* delineated the various public policy reasons underlying the exhaustion doctrine:

> (1) to reduce frivolous lawsuits under ERISA;
> (2) to promote consistent and uniform treatment of claims and benefits;
> (3) to provide a nonadversarial method of claims settlement, and to encourage private resolution of ERISA related disputes; . . .
> (4) to minimize the cost of claims settlement for all parties involved;
> (5) to foster the intent of Congress and the Secretary in establishing administrative remedial procedures which were to be regularly used by aggrieved claimants; . . .

> (6) that prior considered actions by plan trustees or administrators interpreting their plans, refining and defining problems in cases, may well assist the courts in resolving the controversies eventually litigated.
> 819 F. Supp. at 122 (citations omitted).

The court of appeals acknowledged that Heller received no adequate notice of benefit denial nor details of the appeal process. Yet it concluded that because her lawyer filed suit and ultimately knew of an appeal process, the statute and regulations were complied with somehow. This ignored the established fact that no appeal procedure did exist, that her lawyer knew it, and that the insurance company consistently refused to consider any change in position at the same time it suggested an appeal right existed. Such form over substance effort at facial compliance with the law is inexcusable, but this Court of Appeals ignored reality.

As most courts recognize, a comprehensive administrative procedure allows a claimant to effectively appeal a denial of benefits without resorting to costly and time-consuming litigation. In order to be effective, however, such review process must afford the claimant a full and fair opportunity to be notified of the reasons for denial and the appeal procedure. Courts such as the one in *McLean Hospital* appear to favor a strict reading of the law and regulations, while others, such as the court of appeals in our case, seem to

lean toward a more elastic or wishful interpretation of the notice and review requirements. Given the significance of the policy considerations underlying the exhaustion doctrine, this Court should address the issue and provide clear guidance to the lower courts as to meaningful due process rights at the administrative level. The alternative is more litigation in the federal courts that adopt the closed-eye approach endorsed by the court below.

Furthermore, ERISA was enacted for the specific purpose of protecting the rights of plan participants and beneficiaries against misconduct by fiduciaries because Congress recognized the potential for abuse inherent in the scheme of benefit plans. Thus, courts generally read the facts of each case in a manner favorable to the participants and beneficiaries. The court in *Short v. Central States, Southeast & Southwest Areas Pension Fund*, 729 F.2d 567, 575 (11th Cir. 1984), wrote, "ERISA and its accompanying regulations 'were intended to help claimants process their claims efficiently and fairly; they were not intended to be used by the Fund as a smoke screen to shield itself from legitimate claims'." (citing *Richardson v. Central States, Southeast & Southwest Areas Pension Fund*, 645 F.2d 660, 665 (8th Cir. 1981)). Moreover, the court of appeals for the Seventh Circuit held in *Halpin* that "the purpose of the regulations [is]: to afford the beneficiary and the courts a sufficiently precise understanding of the ground for the denial to permit a realistic possibility of review. . . . Given a plan's non-compliance with the

regulations, it is hardly our responsibility to scour the record in an effort to justify the plan's decision." 962 F.2d at 694. Such sentiments, with their solid intellectual basis, are sorely missing in the *Heller* decision.

Finally, courts acknowledge the conflict of interest inherent in benefit plan structures. In *Brown v. Blue Cross & Blue Shield of Alabama*, 898 F.2d 1556, 1561 (11th Cir. 1990), the court wrote that a pension plan provider's "fiduciary role lies in perpetual conflict with its profit-making role as a business." *See also Taft v. Equitable Life Assurance Society*, 9 F.3d 1469, 1474 (9th Cir. 1993). The court in *Wilson v. Group Hospitalization and Medical Services, Inc.*, 791 F. Supp. 309 (D.D.C. 1992), underscored this notion when it found, "[t]he inherent conflict between the fiduciary responsibilities of the insurance carrier and its own financial interests renders the insurance carrier's interpretation of the plan suspect and requires that the Court scrutinize the carrier's interpretation with great care to determine whether the carrier acted free of self-interest." Such language demonstrates most courts' recognition that the Congressional intent behind ERISA and the organizational structure of benefit plans require courts to resolve questions of interpretation in favor of beneficiaries. Especially is this so when an insurance company's self-interest and profit making resolve, as here, is pitted against the interest of the disabled, injured individual. This Court should thus review the decision of the court of appeals in *Heller* and then make certain that lower courts

uphold the purpose of ERISA to protect the rights and interests of claimants seeking fair resolution of their disputes rather than punishment for daring a contest with an insurance company plan administrator.

CONCLUSION

More than two decades after the enactment of ERISA, over 66 million employees rely on the approximately 900,000 pension and benefit plans in existence. It is outrageous that a meaningful due process administrative notice and review procedure fails to exist for benefit denials to many of these plan participants. The *Heller* court's simplistic approval of the insurance company plan administrator's refusal to play by statutory and regulatory rules at the expense of the plan participant, encourages further abridgement of basic rights. It encourages more litigation, to the detriment of the federal court system and significant expense to all parties.[9] This, coupled with the split of the circuit courts on the issue of restitution, mandates resolution of these issues by this Court. Because the issues presented affect a significant portion of the population, and because the case involves important legal and

---

[9]Even the Wall Street Journal, no champion of extending ERISA plan administrator liability, stated editorially last month: "A better solution would be to amend ERISA to require shielded plans to set up independent and clinically competent physician-review panels to decide, in a timely fashion, what is and what isn't medically necessary." Sue Your HMO? Bad Idea, Wall St. J., June 12, 1998.

policy questions, the petition for a writ of certiorari should be granted.

Respectfully submitted,

Joseph F. Cunningham
Counsel of Record

Cunningham & Associates
110 North Royal Street
Suite 401
Alexandria, Virginia 22314
(703) 684-0069

Attorney for Petitioner

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

Argued March 17, 1998 Decided May 1, 1998

No. 97-7095

ANDREA HELLER,
APPELLANT

v.

FORTIS BENEFITS INSURANCE COMPANY,
APPELLEE

Appeal from the United States District Court
for the District of Columbia
(No. 92cv00549)

Joseph F. Cunningham argued the cause and filed the briefs for appellant.

Jennifer Rand Stein argued the cause for appellee, with whom *Grace E. Speights* was on the brief.

Before: WALD, SILBERMAN and ROGERS, *Circuit Judges.*

Opinion for the Court filed by *Circuit Judge* ROGERS.

ROGERS, *Circuit Judge*: Andrea Heller appeals the grant of summary judgment to Fortis Benefits Insurance Company ("Fortis") on her claim that the company improperly denied her disability benefits and breached its fiduciary duty in violation of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461 (1994). After paying Heller disability benefits for five years, Fortis determined that she no longer qualified as disabled under its plan and terminated her benefits. The district court approved this termination and further ordered Heller to reimburse Fortis for disability payments for which she had not actually been eligible. Because Heller failed to present a genuine issue of material fact regarding her qualification for disability benefits under Fortis' plan, and because we hold that restitution was an available remedy for the company under ERISA and that the district court did not abuse its discretion in ordering the award, we affirm.

I.

Heller worked as a marketing representative for McCue Systems, Inc. ("McCue"), beginning in March 1985. The job was stressful, and she injured her back, neck, and shoulder by carrying heavy computer equipment on numerous business trips. In January 1986, she filed for disability under McCue's health benefits plan, which provided for insurance

coverage from Fortis.[1] In order to qualify as "totally disabled" under the plan and thus be eligible for payments, she had to be "unable to perform the material duties of . . . her regular occupation or employment." Agreeing that she qualified for payments as a "totally disabled" person under this definition, Fortis approved Heller's claim. She accordingly received disability benefits from Fortis for five years, from 1986 through 1991.

Under Heller's plan, however, the standards for her eligibility for benefits changed after five years and, by letter of February 4, 1991, Fortis informed Heller that it would review her continued entitlement to benefits. As Heller's plan provided, a person is "totally disabled" if

> A. *Occupation Test*
> (i) during the first 60 months of any One Period of Total Disability, the Person Insured is under the regular care and attendance of a Licensed Physician (other than him or herself) and unable to perform the material duties of his or her regular occupation or employment;

---

[1]McCue purchased the plan from the Mutual Benefit Insurance Company, which was succeeded as the company responsible for administering the plan by Fortis in 1991. For ease of reference, we refer to Heller's insurer throughout as "Fortis."

and

(ii) after the first 60 months of any One Period of Total Disability, the Person Insured is unable to perform the material duties of any and every gainful occupation or employment for which the person is or becomes reasonably fitted by education, training or experience.

While a Person Insured meets these requirements, limited employment will not interrupt the Qualifying Period or the Period of Total Disability.

B. *Earnings Test*

If a Person Insured is working, and is not disabled by the Occupation Test definition of Total Disability, we will consider the Person Insured to be "Totally Disabled" during any month when he or she is not able, because of Injury, sickness or pregnancy, to earn more than 50% of his or her Monthly Earnings.

Fortis advised Heller that it would investigate the merits of her continued claim for benefits and that "the issuance of any further benefits should not be construed as an admission of liability on our part to continue benefits indefinitely beyond the first sixty months of disability."

Thereafter, Fortis commissioned Crawford &

Company ("Crawford"), an employment consulting firm, to interview Heller, assess whether she could perform any jobs, and conduct a labor market survey to determine what jobs might be available for her. In its "Initial Vocational Assessment" report on March 22, 1991, Crawford concluded that Heller "possesses many transferable skills from her work history that would be useful in other less physically demanding types of work," based on her experience, college education, and sales skills. From May 10 through June 5, 1991, Crawford conducted a "Labor Market Survey" that indicated that Heller "has good transferrable skills that apply to different types of jobs that are presently available in the labor market, and those are too numerous to list here, but include customer service, bank positions, any retail, etc." Crawford listed ten sales positions for which Heller might be particularly suited.[2]

Additionally, Fortis dispatched its in-house investigator to determine whether Heller was working at her husband's law firm during the time that she was receiving disability benefits. The investigator determined that Heller spent some time at the firm during the workday, and he also found some documents implying that she worked there—for instance, a letter referring to her editing assistance. However, neither Heller's social security and tax records nor the law firms's

---

[2]Relying on telephone calls made one year after Crawford completed its survey, Heller disputes the availability of these jobs.

records provided documentation of such employment or income; nor did she ever notify Fortis of any return to work or receipt of new income.

Finally, Fortis assembled the medical reports on Heller from examinations since the onset of her disability. Three physicians pronounced her fit for certain kinds of employment. In 1987, Dr. Philip Pulaski concluded that he "would have a hard time, at least from the neurologic perspective, continuing to back up her claims of disability." In 1989, Dr. John Devor concluded that "[m]ost of the time, [Heller] probably would not have more than a slight handicap working either as an outside salesperson or an inside salesperson." In 1990, Dr. Louis Levitt concluded: "In my opinion the patient is not totally disabled from gainful employment." In addition, Dr. Raymond Drapkin, Heller's attending physician, who had been of the opinion that Heller had been disabled, agreed on January 23, 1991, in response to a questionnaire sent by Fortis, that Heller was a good candidate for vocational rehabilitation. On September 6, 1991, in response to another questionnaire, Dr. Drapkin further agreed that Heller could be available for "light work duty" and was "OK" for "sedentary work." He answered in the affirmative the question whether she could "possibly return to work on a full-time basis as an inside salesperson where she is not require[d] to travel or lift heavy equipment and where she is allowed to alternate her position when necessary."

Based on its investigation, Fortis concluded that Heller satisfied neither the plan's Occupation Test nor its Earnings Test, and therefore was unqualified to receive benefits. By letter of January 15, 1992, Fortis notified Heller of the termination of her benefits. After outlining the medical information and the information provided by Crawford, the letter stated: "Based on the medical information and the results of the Labor Market Survey, benefits could be denied on these findings alone[;] however we also have information documenting that [Heller] has worked ... since 12/19/88." In addition to terminating her benefits, Fortis demanded repayment of "benefits that were not due." The letter did not advise her of any right to appeal the benefits determination.

Heller sent a number of documents to Fortis, to which Fortis responded both in writing and by telephone conversation with Heller's attorney that it would treat the documents as an appeal of its benefits determination. Nonetheless, two days after receiving this notice from Fortis, Heller filed suit alleging, among other things, violation of ERISA, specifically, 29 U.S.C. § 1132(a)(1)(B), which provides that "[a] civil action may be brought . . . by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B) (1994). Fortis counterclaimed for restitution of benefits paid Heller after January 1991. The district court resolved the case

on cross-motions for summary judgment, ruling in Fortis' favor on both Heller's claim and its counterclaim. The court found that Fortis was entitled to $19,811.00 in restitution, the amount erroneously paid to Heller after her fifth year of receiving benefits.

II.

On appeal Heller contends that the district court erred in granting summary judgment against her because Fortis denied her a meaningful review process in violation of 29 U.S.C. § 1133. She also contends that the district court failed to apply either test for "total disability" properly in the context of a motion for summary judgment. Under the Occupation Test, she maintains, the severity of her disability presented a material question of fact. Furthermore, she maintains that the district court could not have concluded that she failed the Earnings Test on the basis of sparse medical evidence and undocumented allegations that she was working at her husband's law firm. Finally, she contends that the district court erred in awarding Fortis restitution. Our review of the grant of summary judgment, as well as the denial of Heller's own motion for summary judgment, is *de novo*. *See Henke v. Department of Commerce*, 83 F.3d 1445, 1448 (D.C. Cir. 1996); *Tao v. Freeh*, 27 F.3d 635, 638 (D.C. Cir. 1994).

Rule 56(c) of the Federal Rules of Civil Procedure

provides that a court shall grant a motion for summary judgment if "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." FED. R. CIV. P. 56(c). Facts are deemed "material" if a dispute over them "might affect the outcome of the suit under the governing law." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). A factual dispute is "genuine" where "the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Id.* The moving party has the burden of demonstrating the absence of a genuine issue of fact for trial. *See id.* at 256. If the moving party satisfies this burden, Rule 56(e) provides:

> When a motion for summary judgment is made and supported as provided in this rule, an adverse party may not rest upon the mere allegations or denials of the adverse party's pleading, but the adverse party's response, by affidavits or as otherwise provided in this rule, must set forth specific facts showing that there is a genuine issue for trial. If the adverse party does not so respond, summary judgment, if appropriate, shall be entered against the adverse party.

FED. R. CIV. P. 56(e).

A.

Because Heller made her disability claim through an insurance plan offered by her employer, this coverage case is governed by ERISA. *See* 29 U.S.C. §§ 1002(1), 1003(a) (1994). Section 503 of ERISA provides that

> every employee benefit plan shall—
>
> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
>
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

Id. § 1133. Initial claims handling must be completed within time limits prescribed by the Secretary of Labor. *See* 29 C.F.R. § 2560.503-1(e) (1997). If a claim is denied, the fiduciary reviewing the denial must act promptly and within time periods prescribed by the Secretary of Labor following any request for review by the plan participant. *See id.* § 2560.503-1(h). The Secretary has fixed that time period in most cases at 120 days:

> A decision by an appropriate named fiduciary shall be made promptly, and shall not ordinarily be made later than 60 days after the plan's receipt of a request for review, unless special circumstances (such as the need to hold a hearing, if the plan procedure provides for a hearing) require an extension of time for processing, in which case a decision shall be rendered as soon as possible, but not later than 120 days after receipt of a request for review.

Id. § 2560.503-1(h)(1)(i). If the decision is not rendered within the 120-day period, the claim is deemed denied on review, *see id.* § 2560.503-1(h)(4), and the claimant may "bring a civil action to have the merits of his application determined, just as he may bring an action to challenge an outright denial of benefits," *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 144 (1985). Delay in the processing of an application or appeal does not, however, give rise to a private right of action for compensatory or punitive relief. *See id.*

The relevant regulations also provide that the notice required by section 1133 includes "appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review." 28 C.F.R. § 2560.503-1(f)(4). Fortis never advised Heller of her right to appeal in its denial letter. However, this would not necessarily render summary judgment in favor of Fortis inappropriate given its

substantial compliance with section 503 of ERISA and its accompanying regulations. *See, e.g., Brehmer v. Inland Steel Indus. Pension Plan,* 114 F.3d 656, 662 (7th Cir. 1997); *Kent v. United of Omaha Life Ins. Co.*, 96 F.3d 803, 807 (6th Cir. 1996). Indeed, "when claim communications as a whole are sufficient to fulfill the purposes of Section 1133 the claim decision will be upheld even if a particular communication does not meet those requirements. *Kent,* 96 F.3d at 807. Here, before Heller filed her lawsuit, she was informed of her right to appeal and that appeal proceedings were being commenced. Fortis advised Heller through her present attorney on February 19, 1993, a month after sending the termination later, that it would treat various documents sent by her as an appeal. Thus, although the initial letter from Fortis informing Heller of the denial of her disability benefits did not conform to the requirements of the regulations, "the procedures, when viewed in light of the myriad communications between claimant, her counsel and the insurer, [appear] sufficient to meet the purposes of Section 1133 in insuring that the claimant understood the reasons for the denial of [her benefits] as well as her rights to review of the decision." *Id.* at 807.

In any event, Heller now asserts that even if Fortis had resolved her appeal, the established review process was essentially meaningless because it consisted merely of the claims adjuster's reconsideration of his own work. But we have no occasion to determine whether Fortis' procedural

shortcomings violated 29 U.S.C. § 1133 and its attendant regulations, and, if so, what remedy might be appropriate, because Heller never attempted to make use of Fortis' appeal process. While the insurer offered to treat Heller's correspondence as an appeal of its denial of benefits, Heller did not wait to see how the appeal would be resolved. Instead, she filed her lawsuit two days after Fortis' February 19th offer. Not only did she shortcut any review that might have occurred, but she even asserted in her complaint that she had exhausted her administrative remedies. Under the circumstances, she cannot establish that she was denied "a fair opportunity for review" of her claim because she never gave Fortis a chance to complete its review. *Id.* at 807. Nor can she show that Fortis' processing of her claim denial prejudiced her because she immediately filed suit against the insurer. *See Hancock v. Montgomery Ward Long Term Disability Trust,* 787 F.2d 1302, 1308 (9th Cir. 1986). By doing so before exhausting the remedies provided by her insurer, Heller's position now is no different than it would have been if Fortis had neglected to process her correspondence as an appeal. *See* 29 C.F.R. § 2560.503-1(h). In either event, her next move would have been to file suit in the district court. *See Massachusetts Mut. Life Ins. Co.*, 473 U.S. at 144.

B.

Under the Occupation Test in Fortis' plan, insureds are considered "totally disabled" (after the first five years of

disability) if they are "unable to perform the material duties of any and every gainful occupation or employment for which the person is or becomes reasonably fitted by education, training or experience." Heller contends that there was a genuine issue of material fact whether she was unable to perform the duties of any gainful occupation and whether there were any job opportunities for which she was reasonably fitted.

Heller's examining and treating physicians agreed, however, that she was able to work in 1992, and she presented no evidence to contravene the Crawford report that jobs were available to her. "Courts review ERISA-plan benefit decisions on the evidence presented to the plan administrators, not on a record later made in another forum," *Block v. Pitney Bowes Inc.*, 952 F.2d 1450, 1455 (D.C. Cir. 1992), and all the evidence available to Fortis when it made its claim decision suggested that Heller was able to work as a medical matter, at least in a sedentary occupation. Not only had three outside medical examiners concluded that she was not disabled, but her own attending physician, Dr. Drapkin, also advised Fortis that Heller was ready for "light work duty" and "sedentary work." Because Dr. Drapkin's January 15, 1997, declaration that he had always thought his patient was disabled, regardless of his earlier conclusions as to her suitability for sedentary work, was unavailable to Fortis before it denied Heller's claim for further benefits on January 15, 1992, that declaration may not be considered now. *See id.* Hence, there

is no genuine factual dispute about the medical conclusions available to Fortis at the time it terminated Heller's benefits. Those medical conclusions unanimously indicated that Heller was capable of some work.

Nor was there a genuine question of material fact as to the availability of employment for which Heller would have been "reasonably fitted by education, training or experience," as required by the plan. Heller was confronted with Crawford's vocational assessment indicating that she was a good candidate for employment in inside sales because she had transferrable skills, a college education, and job experience. Heller presented Fortis with nothing to challenge that assessment other than speculation that it would be difficult at her age for her "realistically" to get one of the inside sales jobs, and that the jobs might pay minimum wage. Her evidence that none of the several jobs listed by Crawford were still available one year later did not undermine Crawford's assessment; certainly it did not indicate that similar jobs were unavailable. Therefore, although "the burden of proof is upon the insured as to questions of coverage and disability," 20 JOHN ALAN APPLEMAN & JEAN APPLEMAN, INSURANCE LAW AND PRACTICE § 11376 (1980) (footnote omitted) (citing cases); *cf. Perdue v. Burger King Corp.*, 7 F.3d 1251, 1254 n.9 (5th Cir. 1993), Heller did not provide Fortis with evidence suggesting that she had "an impairment which would prevent [her] from performing some identifiable job," *See McKenzie v. General Telephone Co.*, 41

F.3d 1310, 1317 (9th Cir. 1994). Heller did not present any evidence to Fortis sufficient to establish her right to benefits under the company's Occupation Test.

Nor can Heller prevail under the alternative Earnings Test. Under that test, an insured who "is not able, because of Injury, sickness or pregnancy, to earn more than 50% of his or her Monthly Earnings" before going on disability is entitled to benefits. The most important part of this definition for Heller is the phrase "able . . . to earn." Crawford's analysis of Heller's employment prospects concluded that she was qualified for a number of available inside sales jobs, and listed a number of examples paying base salaries between $20,000 to $35,000 per year. The wages from these jobs exceeded 50% of the roughly $35,000 that Heller made when she was working for McCue prior to her disability.[3] Again, Heller has presented no evidence to show that she could not find a job

---

[3]Indeed, under Fortis' interpretation of its Occupation Test, a "gainful" occupation is an occupation that pays at least the amount of the gross monthly long-term disability benefit that the claimant receives from Fortis—in Heller's case, $1801 per month. Thus, when it denied Heller's claim under that test, Fortis necessarily found that Heller could earn at least $1801 per month, which is more than one half of Heller's average monthly salary at McCue and thus sufficient to satisfy the Earnings Test. As noted, Heller has not presented evidence sufficient to sustain a claim against Fortis' application of its Occupation Test.

that would pay at least 50% of the salary she earned at McCue, despite her obligation to do so. *See* FED. R. CIV. P. 56(e).

For these reasons, the district court properly concluded that the medical and occupational evidence before Fortis at the time of its decision to terminate benefits was sufficient to support that decision. Because Heller has presented no contradictory evidence, we need not reach other disputed but nonmaterial issues of fact, such as whether Heller actually was working for her husband's law firm, in order to affirm the grant of summary judgment.

III.

This circuit has not previously decided whether there is a cause of action for restitution under ERISA. Fortis filed its counterclaim for restitution pursuant to ERISA's provision that "[a] civil action may be brought . . . by a . . . fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief . . . to redress such violation." 29 U.S.C. § 1132(a)(3). As the Third Circuit concluded in *Luby v. Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176 (3d Cir. 1991), "[a]lthough ERISA itself does not explicitly provide a statutory right of restitution, it is clear that Congress intended federal courts to fashion a federal common-law under ERISA, and this permits application of a

federal common-law doctrine of unjust enrichment." *Id.* at 1186. A number of courts have created an unjust enrichment remedy, permitting ERISA fiduciaries such as Fortis to seek restitution against third parties who wrongly or mistakenly receive money to which the plan is entitled. *See, e.g., Blue Cross & Blue Shield of Ala. v. Weitz*, 913 F.2d 1544, 1548-49 (11th Cir. 1990); *Provident Life & Accident Ins. Co. v. Waller*, 906 F.2d 985, 994 (4th Cir. 1990). *But see NYSA-ILA GAI Fund v. Poggi*, 617 F. Supp. 847, 849 (S.D.N.Y. 1985). As the district court correctly concluded, this furthers the goal of ERISA to safeguard "the corpus of funds set aside" under the plan.[4] *Luby*, 944 F.2d at 1186; *see also Printing Industry of Ill. Employee Benefit Trust v. Stout*, 157 F.R.D. 448, 451 (N.D. Ill. 1994) ("[D]enial of a federal cause of action would ultimately undermine ERISA's goal of expanding pension and welfare benefit plan coverage."). Accordingly, we hold that Fortis could properly seek restitution under ERISA.

The question remains whether the district court properly granted Fortis restitution. Here, the scope of our

---

[4]While *Luby* itself is different from the instant case to the extent that it involved a mistaken payment to a nonbeneficiary instead of a disputed payment to a beneficiary, the principle remains the same. In both cases the recipient of the money receives benefits to which she is not entitled, a cost unfairly borne by the other members of the plan. *See Weitz*, 913 F.2d at 1548.

review is more limited than with regard to whether restitution was a possible remedy; we only review awards of restitution for abuse of discretion. *See United States v. Rezaq*, 134 F.3d 1121, 1141 (D.C. Cir. 1998). Generally, restitution is an appropriate remedy where there is unjust enrichment:

> three elements encompass the equitable remedy of unjust enrichment and quasi-contract: the plaintiff must show that (1) he had a reasonable expectation of payment, (2) the defendant should reasonably have expected to pay, or (3) society's reasonable expectations of person and property would be defeated by nonpayment.

Waller, 906 F.2d at 993-94 (citing COLIN KELLY KAUFMAN, CORBIN ON CONTRACTS § 19A, at 50 (Supp. 1989)). Heller contends that the restitution ordered by the district court was unfair essentially because she had not been notified that the company would seek restitution until it terminated her payments. Her plan did not specifically provide for restitution and Fortis never expressly stated that its payment of the benefits after the five year term expired was conditional. Yet the district court was presented with evidence that Fortis had previously notified Heller in writing that its payment of benefits after the first five years could not be deemed an admission of liability. Reasonably viewed, Fortis thereby notified Heller that it expected reimbursement for benefits for

which she was not eligible. It is true that the plan did not expressly provide for restitution, but nothing in the plan prohibited such recovery by Fortis. While it might well be preferable for the plan to be explicit on the point, notice by letter may well afford more effective notice than a provision buried in a lengthy policy statement. The district court, therefore, did not abuse its discretion in ordering restitution in such circumstances.

Accordingly, we affirm the judgment.

Andrea HELLER (Whitesell), Appellant,

v.

MUTUAL BENEFIT LIFE INSURANCE COMPANY, aka Fortis Benefits Insurance Company, aka Western Life Insurance Company, et al.

No. 92-7148.

United States Court of Appeals, District of Columbia Circuit.

Sept. 30, 1993.

Appeal from the United States District Court, for the District of Columbia, No. 92cvOO549.
D.D.C.

AFFIRMED.

Before BUCKLEY, GINSBURG, and HENDERSON, Circuit Judges.

JUDGMENT
PER CURIAM.

This cause was considered on the record from the United States District Court and on the briefs and oral arguments by counsel. After full review of the issues presented, the court concludes that appropriate disposition of the appeal does not warrant an opinion. See D.C.Cir.R. 14(c). Andrea Heller contests the termination of payments under a group disability insurance policy underwritten by the Mutual Benefit Life insurance Company. She appeals the district court's dismissal of her amended complaint for failure to state a claim under which relief can be granted pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure. While Ms. Heller had amended her complaint to bring it under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq., and appears to have framed it on the assumption that Mutual exercised discretionary authority to determine eligibility for benefits under the plan, she failed to allege facts which, if proven, would have established that Mutual's decision to suspend her disability payments was arbitrary and capricious. *See Firestone Tire & Rubber Co. v. Brady*, 489 U.S. 101, 115 (1989); *Block v. Pitney Bowes, Inc.*, 952 F.2d 1450, 1452 (D.C.Cir. 1992).

At the same time, we note that in a footnote to its Memorandum Opinion, the district court indicated that the dismissal was without. prejudice: "if plaintiff does file an amended complaint she should make certain to plead . . .

elements of an ERISA claim currently lacking in the complaint." *Heller v. Mutual Life Ins. Co.*, No. 92-0549, Mem.Op. at 6 n. 2 (D.D.C. June 26, 1992). Mutual agreed at oral argument that Ms. Heller is free to file a second amended complaint and, if she so chooses, to plead in the alternative in order to state a valid claim for de novo review. See *Firestone*, 489 U.S. at 115.

It is therefore ORDERED AND ADJUDGED by the court that the dismissal of Ms. Heller's amended complaint be affirmed.

The Clerk is directed to withhold issuance of the mandate herein until seven days after disposition of any timely petition for rehearing. See D.C.Cir.Rule 15. This instruction to the Clerk is without prejudice to the right of any party at any time to move for expedited issuance of the mandate for good cause shown.

APPENDIX B

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF COLUMBIA

Andrea HELLER (Whitesell), Plaintiff,

V.

MUTUAL BENEFIT LIFE INSURANCE COMPANY, aka Fortis Benefits Insurance Company, aka. Western Life Insurance Company, Defendant.

No. Civ. A. 92-0549.

United States District Court, District of Columbia.
June 18, 1992.

MEMORANDUM OPINION

NORMA HOLLOWAY JOHNSON, District Judge.

This case is presently before the Court on plaintiff's motion for preliminary injunction. Plaintiff, Andrea Heller (Whitesell), asks the Court to enjoin defendant Fortis Benefits Insurance, Co., from terminating her disability insurance benefit payments. Heller was employed by McCue Systems, Inc., a California company, from March 1985 to March 1986. After suffering back, neck and shoulder injuries as a result of her employment, she began receiving disability benefits in January 1986. In February 1991, Fortis informed Heller that it was investigating the status of her disability claim and,

following the investigation, terminated her benefits in January 1992. The termination was based upon a finding by Fortis that under both applicable California law and the terms of the insurance policy Heller no longer was totally disabled. Heller challenges the termination claiming that, under the requisite standards, she remains totally disabled and is entitled to the continuation of disability benefits.

DISCUSSION

In order to obtain a preliminary injunction plaintiff must demonstrate that she is likely to succeed on the merits, that she will suffer irreparable harm if an injunction is not granted, that an injunction will not unduly harm other interested parties and that the public interest will be served by an injunction. See *Washington Metropolitan Area Mass Transit Commission v. Holiday Tours*, 559 F.2d 841 (D.C. Cir. 1977), *Virginia Petroleum Jobbers Association v. Federal Power Commission*, 259 F.2d 921 (D.C.Cir.1958).

1. Likelihood of Success on the Merits

Plaintiff contends that she is likely to succeed on the merits of her claim that Fortis wrongfully terminated her long-term disability benefits in contravention of controlling California law and the language of the insurance policy between her and defendant. Fortis challenges this claim

asserting that plaintiff is not "totally disabled" under either controlling California law or the language of the insurance policy.

The insurance policy states that during the first sixty (60) months following an injury an employee is considered "totally disabled" if she "is unable to perform the material duties of . . . her regular occupation or employment." After the first sixty (60) months, the definition changes and an employee is considered "totally disabled" if she "is unable to perform the material duties of any and every gainful occupation or employment for which the person is or becomes reasonably fitted by education, training or experience." Under state law a person is totally disabled "within the meaning of the term 'any occupation' . . . whenever the insured is incapacitated from following any substantial or remunerative occupation for which he is fitted or qualified, mentally or physically, and by which he is able to earn a livelihood." *Erreca v. Western States Life Ins. Co.*, 121 P.2d 689 (Cal.1942). Thus, defendant's interpretation of its own policy appears to be in accordance with controlling California law.

In light of the plain language of the insurance policy and applicable state law, however, it appears that plaintiff's continued use of her former position as the measure by which to judge her disability status may be incorrect. The authority presented thus far appears to indicate that the standard is

simply whether Heller is capable of securing any form of gainful employment. Based upon the present record plaintiff has failed to demonstrate that she is likely to succeed on the merits of her claim.

2. Irreparable Harm

Plaintiff claims she will be irreparably harmed if injunctive relief is not granted because without her disability benefits she will be unable to pay her living expenses, including her mortgage. Allegations of economic hardship, especially when those allegations are speculative and unsupported by evidence of record, are simply insufficient to establish irreparable harm for purposes of the extraordinary relief sought by plaintiff. *See Virginia Petroleum Jobbers*, 259 F.2d 921, 925 (D.C. Cir. 1958).

Because plaintiff has failed to demonstrate that she is likely to succeed on the merits or that she will suffer irreparable harm if injunctive relief is not granted, her motion for preliminary injunction must be denied. An Order consistent with this Memorandum Opinion will issue.

ORDER

Upon consideration of the motion of plaintiff for a preliminary injunction, the opposition of defendant, the

argument of counsel, and in accordance with the accompanying Memorandum Opinion, it is this 18th day of June, 1992,

ORDERED that the motion of plaintiff for a preliminary injunction be, and hereby is, denied.